SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Health Indicators: Moving the Needle

Aristotle Sun MD MPH
Medical Director of Population Health & Primary Care
Assurance Health and Wellness Center

PBHCI Grantee Regional Conference

- These modules are intended for PCPs working in public mental health settings, to deal with the health disparity experienced by patients with (SMI).
- Goal: to help facilitate their work in this environment, which may be unfamiliar to many PCPs, so they can best serve this population of patients.
  - ❑ Understanding the Target Population
  - ❑ Building an Integrated Care Team
  - ❑ Moving the Dial

Understanding the Target Population

What do we know about the SMI Population?

1. The premature mortality seen in the SMI population is:	• 25-30 years • 20-25 years • 15-20 years • 10-15 years
2. What percent of diseases contributing to the early mortality in SMI is likely preventable?	• 20% • 40% • 60% • 80%
3. What are the leading illnesses that contribute?	• Cardiovascular • Infectious disease • Cancers • All of the Above
4. How much does smoking increase the risk of death in SMI population?	• 1.5x • 2.0x • 3.0x

Different models must be tested – the cost of suffering and doing nothing is unacceptable.”

Vieweg, et al., American Journal of Medicine. March 2012

Why primary care services in mental health?

- High rates of physical illness in severely mentally ill
- Premature mortality, most of it preventable
- Patients with mental illness often receive a lower quality of care
- High cost of physically ill with mental illness
- Access Problems (5 A’s of access to health care)

Treatment Patterns in Mental Illnesses

(Wang et al., 2005 National Comorbidity Survey Replication)

41% of 12-month cases received some form of treatment

- General Medical Provider: 22.8%
- Non-psychiatrist Mental Health Provider: 16.0%
- Psychiatrist: 12.3%
- Human Services Provider: 8.1%
- Complementary/Alternative Medical Provider: 6.8%

Median number of treatment visits conducted

- Mental Health Specialist: 7.4
- General Medical Provider: 1.7

Adequate Treatment Duration:

- Specialty 48.3% vs PCP 12.7%

Cardiovascular Disease is Primary Cause of Death in Persons with Mental Illness

Cardiovascular Disease Risk Factors		
Modifiable Risk Factors	Estimated Prevalence (%) and Relative Risk (RR)	
	Schizophrenia	Bipolar disorder
Metabolic syndrome	37-60%, 2-3 RR	30-49%, 2-3 RR
Dyslipidemia	25-69%, 5 RR	23-38%, 3 RR
Hypertension	19-58%, 2-3 RR	35-61%, 2-3 RR
Diabetes mellitus	10-15%, 2-3 RR	8-17%, 1.5-3 RR
Smoking	50-80%, 2-3 RR	54-68%, 2-3 RR
Obesity	45-55%, 1.5-2 RR	21-49%, 1-2 RR

De Hert M, et al. World Psychiatry. 2011 Feb; 10(1): 52–77

Premature Deaths in Schizophrenia

Standardized Mortality Ratio or SMR is how much more likely death will occur relative to expected in general population

$$SMR = \frac{ObservedMortality}{ExpectedMortality}$$

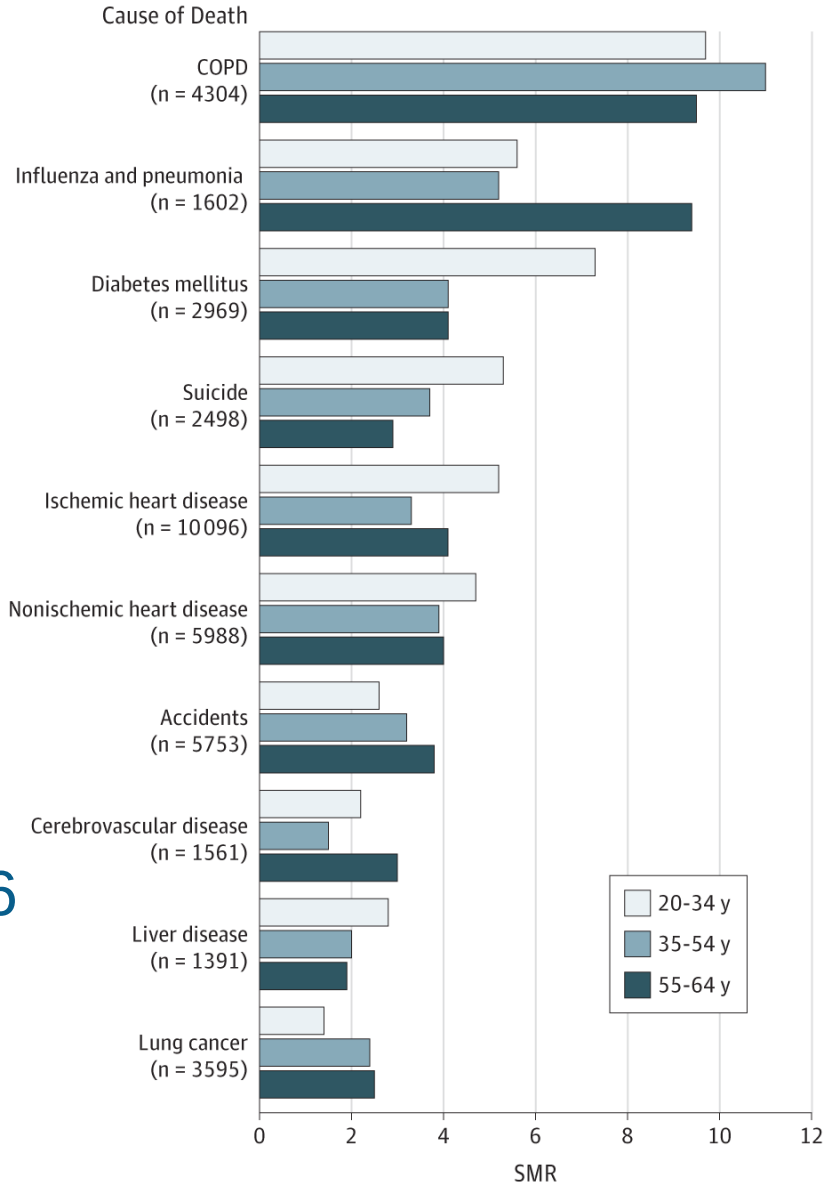
All-cause SMR: 3.7

Cardiovascular disease SMR: 3.6

Lung cancer: 2.4

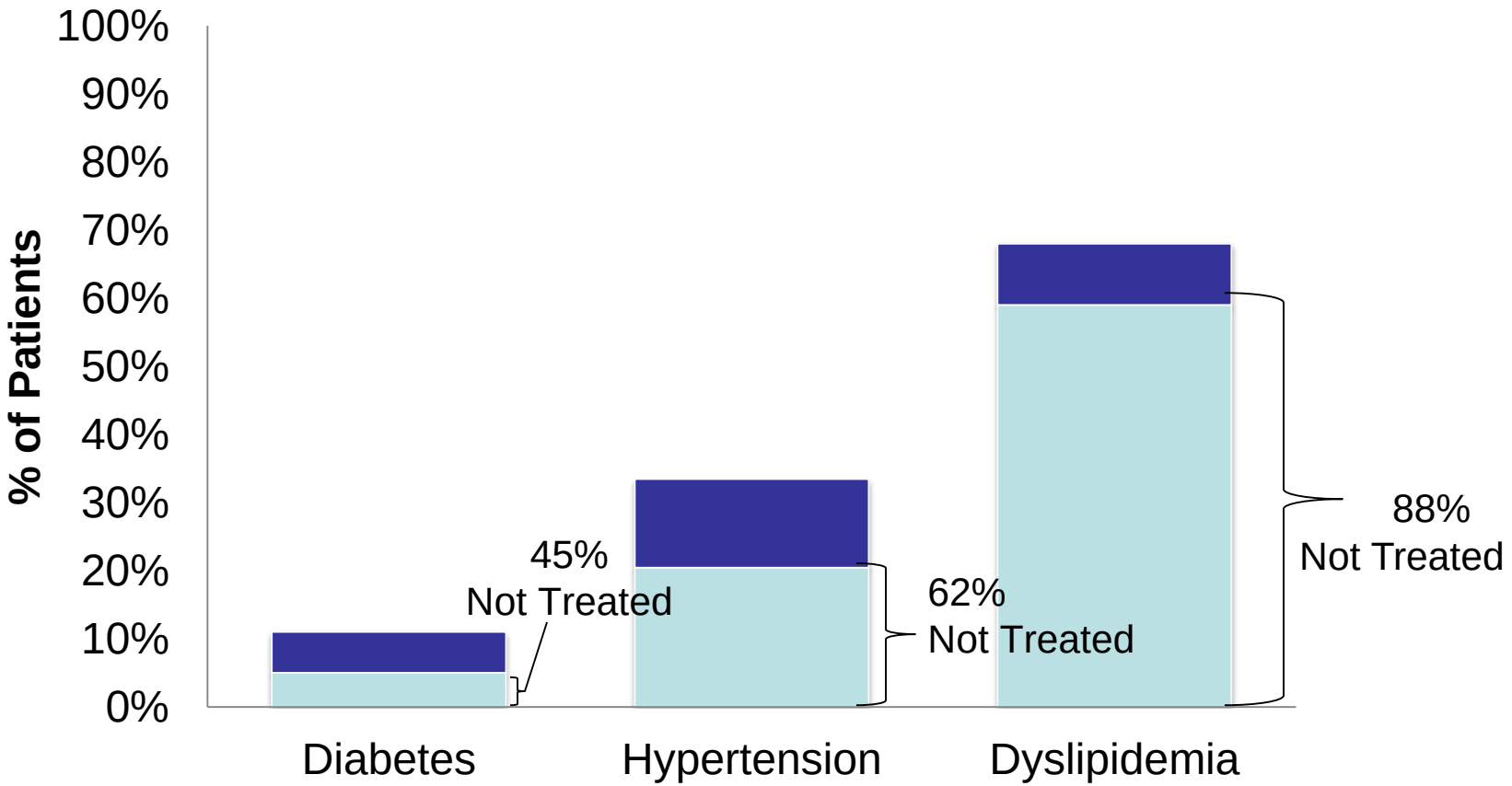
COPD SMR: 9.9

Influenza / Pneumonia SMR: 7.0



Olfson M, et al. JAMA Psychiatry. 2015 Dec; 72(12): 1172-81

Disparities: Rates of Non-treatment



De Hert M, et al. World Psychiatry. 2011 Feb; 10(1): 52–77

5 A's of Access to health care

Access to health care is necessary but not sufficient for high quality health care (policy & management)

Affordability	• Can you afford to see the provider? Can you afford treatments prescribed?
Availability	• Is the provider available to see you? Immediately? Three months to a year?
Accessibility	• Is the provider office accessible to you? Within an hour of your home?
Accommodation	• Can they accommodate your situation (work schedule, disabilities, etc.)?
Acceptability	• Can you accept the provider – personal characteristics, demeanor, personality, etc.?

Ultimately, "meeting people where they are"

How does you or your practice address these deficiencies?

- Prevention of physical health problems
  - Primary (pre-disease)
  - Secondary (pre-symptoms/signs)
  - Tertiary (pre-complications/managing complications)
  - Quaternary (preventing iatrogenic harm)
- Quality of care issues in behavioral health populations
- Adherence and cost management in managing physical health with behavioral health patients
- Access Problems (5 A's of access to health care)

Building an Integrated Care Team

Location + Collaboration = Integration

Integration

Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration Onsite	Close Collaboration/ Partly Integrated	Fully Integrated
Separate systems	Separate systems	Separate systems	Some shared systems	Shared systems and facilities in seamless bio-psychosocial web
Separate facilities	Separate facilities	Same facilities	Same facilities	Consumers and providers have same expectations of system(s)
Communication is rare	Periodic focused communication; most written	Regular communication, occasionally face-to-face	Face-to-Face consultation; coordinated treatment plans	In-depth appreciation of roles and culture
Little appreciation of each other's culture	View each other as outside resources	Some appreciation of each other's role and general sense of large picture	Basic appreciation of each other's role and cultures	Collaborative routines are regular and smooth
	Little understanding of each other's culture or sharing of influence	Mental health usually has more influence	Collaborative routines difficult; time and operation barriers	Conscious influence sharing based on situation and expertise
			Influence sharing	
"Nobody knows my name. Who are you?"	"I help your consumers."	"I am your consultant."	"We are a team in the care of consumers"	"Together, we teach others how to be a team in care of consumers and design a care system."

Where do you fall?

Barriers to Providing Primary Care to SMI Population

Cultural

- Mental health staff and patients not used to incorporating primary care as part of job
- Psychiatric staff feel time pressure to address screening, vital signs and may feel "out of scope" for specialty

Financial

- Limited funding
- Different billing structures
- High no-show rates, takes extra time
- Psychiatric providers frequently not provided resources such as Medical Assistants

Motivational

- Lack of perceived need for care
- Lack of motivation as part of depression and/or negative symptoms of schizophrenia

Organizational

- Devoting space, time, and money
- Specialists do not cross boundaries
- Different languages
- Behavioral health EHRs often lack capacity to track physical health indicators
- Not perceived as part of the Mission

Physical Location

- Proximity is crucial to success
- Same building is good; same suite is better
- Space limitations

Perceived Cultural Differences

Primary Care

- ✓ Continuity is goal
- ✓ No stigma
- ✓ Data more easily shared
- ✓ Larger Panels
- ✓ Flexible scheduling
- ✓ Faster paced
- ✓ Complexity-based
- ✓ Flexible Boundaries
- ✓ Treatment externalized (labs, procedures, medications)
- ✓ Patients are less responsible for illness/treatment

Behavioral Health

- ✓ Termination is goal “close the chart”
- ✓ Stigma common
- ✓ Data more tightly regulated
- ✓ Smaller panels
- ✓ Fixed scheduling
- ✓ Slower pace
- ✓ Time-based, e.g. “50-min hour”
- ✓ Firm Boundaries
- ✓ Relationship with provider is significant part of treatment
- ✓ Patients are responsible for participating in treatment

“You’re killing me with those meds…”

Build a relationship with the behavioral health staff

- Establish lines of communication with the extended BH treatment team
- Understand the importance of Psychopharmacology
- Stabilizing mental illness to treat the medical condition
- Understand the importance of patient goals, shared-decision making, and motivational interviewing
- Harm-reduction – taking a page out of basic public health and behavioral health strategies

Experiences across the cultures

Were those experiences similar to what you experienced or perceived?

Have your perceptions changed over time?

Roles for PCPs in Behavioral Health Settings

Direct Clinical Care	• Primary Prevention (Pre-disease prevention – diet/exercise/smoking cessation) • Secondary Prevention (Screening for disease and complications) • Tertiary Prevention (Treating complications and reducing sequelae) • Quaternary Prevention (Reduce iatrogenic harm such as polypharmacy)
Collaboration	• Paternalistic → Shared Decision Making • Behavioral Health Providers • Care/Case Managers, Peer Navigators
Population-based Care	• Establishing Priorities • Tracking Outcomes • Improving Care Based on Outcomes
Education	• Non-medical Staff • Patients • Families
Leadership	• Champion Healthcare Change • Help Shape Systems of Care

Building the Team

LCSW

Case Manager

Pop Health Admin

Psychiatric Providers

Admin

Nurse

Addiction Specialist

Psychologist

Peers

Primary Care Doctor

Nutritionist

Service Dog

Pharmacist

Core Principles of Collaborative Care

Patient Centered Team Care

- Effective collaboration between PCPs and Behavioral Health Providers
- Nurses, social workers, psychologist, peers, pharmacists, medical assistants, data analysts, and licensed therapists are all equally important to the team

Population-Based Care

- Tracking behavioral & physical health patients in registries: no ones falls through the cracks

Measurement-Based Treatment to Target

- Measurable treatment goals clearly defined and tracked for each patient (individualization of clinical targets is also necessary despite use of registry and population level tracking)
- Treatments are actively monitored and changed until the clinical goals are achieved

Evidence-Based Care

- Treatments with credible research evidence to support their efficacy in treating the target condition

Accountable Care

- Providers are accountable and reimbursed for quality of care and clinical outcomes

AIMS 2015

Team-Based Population Management

Our Team

- ☐ Primary Care Provider
- ☐ Ambulatory Care Clinical Pharmacist
- ☐ Dietician
- ☐ Psychiatrist
- ☐ Therapist
- ☐ Care Manager
- ☐ Peer Support Coaches
- ☐ Population Health Administrator
- ☐ Wellness Educators

Drives our team

General Population	• Treatment resistant or Diagnosis Uncertain
SMI #1	• Loss to follow up • Wanting to get back in to specialty care
SMI #2	• Loss to follow up • Awaiting specialty care – capacity issue
SMI #3	• Refusing Specialty care

What does your team look like?

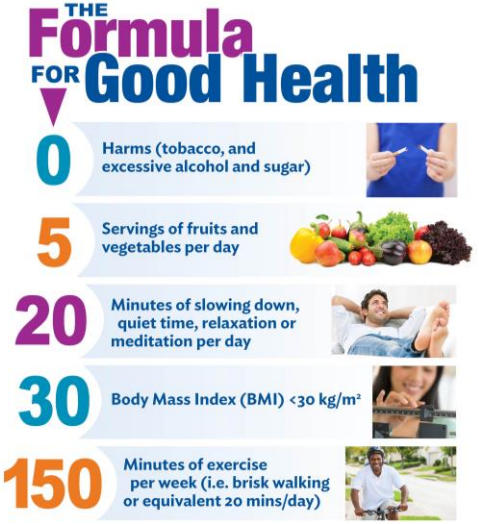
What is your team missing?

What do you think would make your team function more efficiently and more effectively?

Does your organization have the culture for improvement and the climate to foster positive change?

Team Training and Communication

- Show staff the importance of capturing health indicator data
- One pagers – Diabetes, Hypertension
- Share latest articles/websites tracking progress
- Case to Care Training
- Track organizational progress
  - Barriers to enrollment
  - Barriers to capturing data
  - PDSA Workflow Redesigns



Moving the Dial

"We always hope for the easy fix: the one simple change that will erase a problem in a stroke. But few things in life work this way. Instead, success requires making a hundred small steps go right – one after the other, no slipups, no goofs, everyone pitching in."

- Atul Gawande, *Better: A Surgeon's Notes on Performance*

In other words, there are no "silver bullets" in healthcare.

Improvement Requires Baseline

"It is wrong to suppose that if you can't measure it, you can't manage it – a costly myth."

- W. Edwards Deming

But you do need a reference point to improve upon and manage – it does not always need a quantitative value attached to it, but it can certainly help.

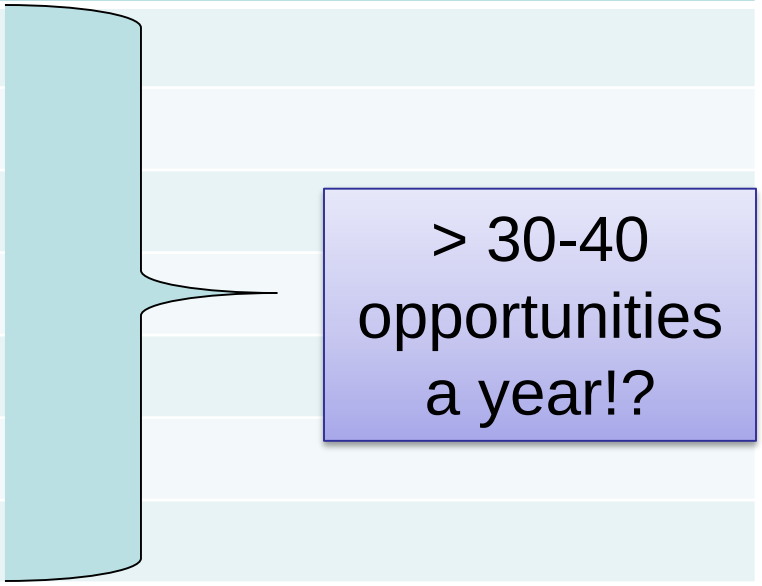
Examples of non-quantifiables include mission, vision, values, organizational culture, staff morale, community contributions, interpersonal interactions, etc.

Continuous Quality Improvement

Graphic credit: Tribal Evaluation Institute

Opportunities for Change

How Many Interactions with Patients in Different Settings During a Year?	
Primary Care	4-6
Mental Health Settings:	
Psychiatrist	4
Nurse	4
Case Manager	20
Therapist/Crisis	5
Peer Specialists	5



When you consider MA, PharmD, dieticians, educators, and start using registries & EHR tracking, the number of opportunities can skyrocket

Monitoring and Treatment Protocols

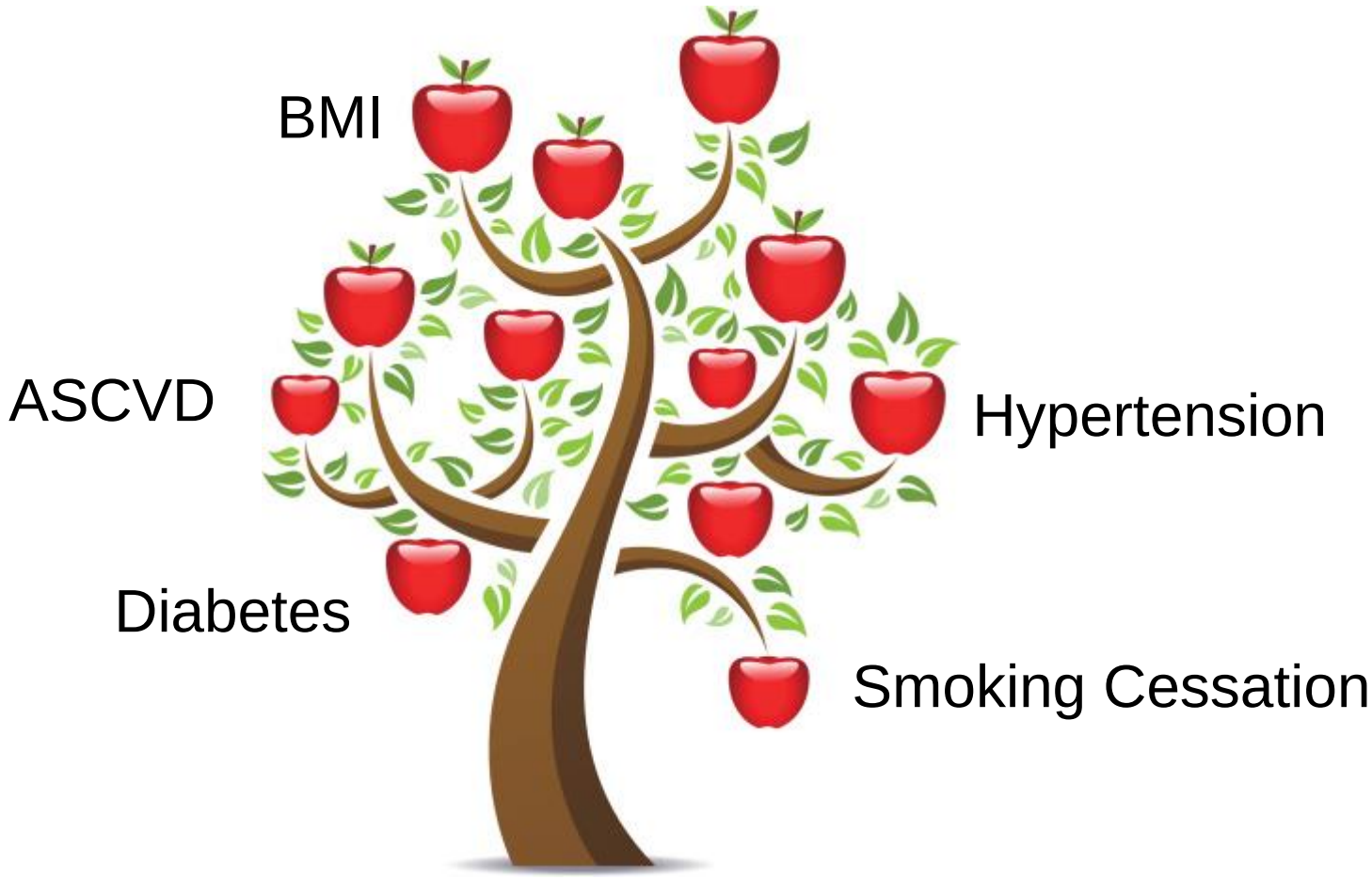
Physical Health checks should focus on monitoring:

- ❑ Weight Gain and Obesity (BMI, WC)
- ❑ Blood Pressure
- ❑ Fasting Blood Glucose / Hgb A1c
- ❑ Lipid Panel / ASCVD Risk
- ❑ Use of tobacco, CO level
- ❑ Use of alcohol and other substances
- ❑ Thyroid Function Testing (if indicated)
- ❑ Medication Reconciliation
- ❑ Activity Level and Exercise
- ❑ Dietary Intake (Na/CHO/veggies)
- ❑ Comprehensive Metabolic Panel
- ❑ Vitamin D levels (if indicated)
- ❑ Complete Blood Count w/ Platelets
- ❑ Dental health
- ❑ Prolactin levels (if indicated)

Standing Protocols

- ❑ Tobacco Cessation
- ❑ Point of Care Testing
- ❑ Diabetes Education Groups
- ❑ Whole Health Action Mgmt (WHAM)

Low Hanging Fruit



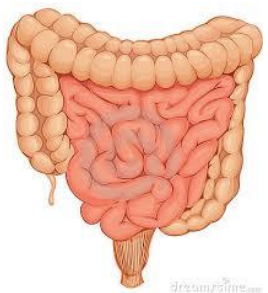
“Force Multiplier Effect”

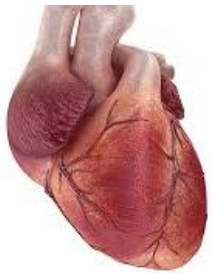
Health Behavior Change

- Behavior change is the expertise of the behavioral health world – but it needs to include physical health
- Motivational Interviewing, Health Action Model

Physical Health Indicators

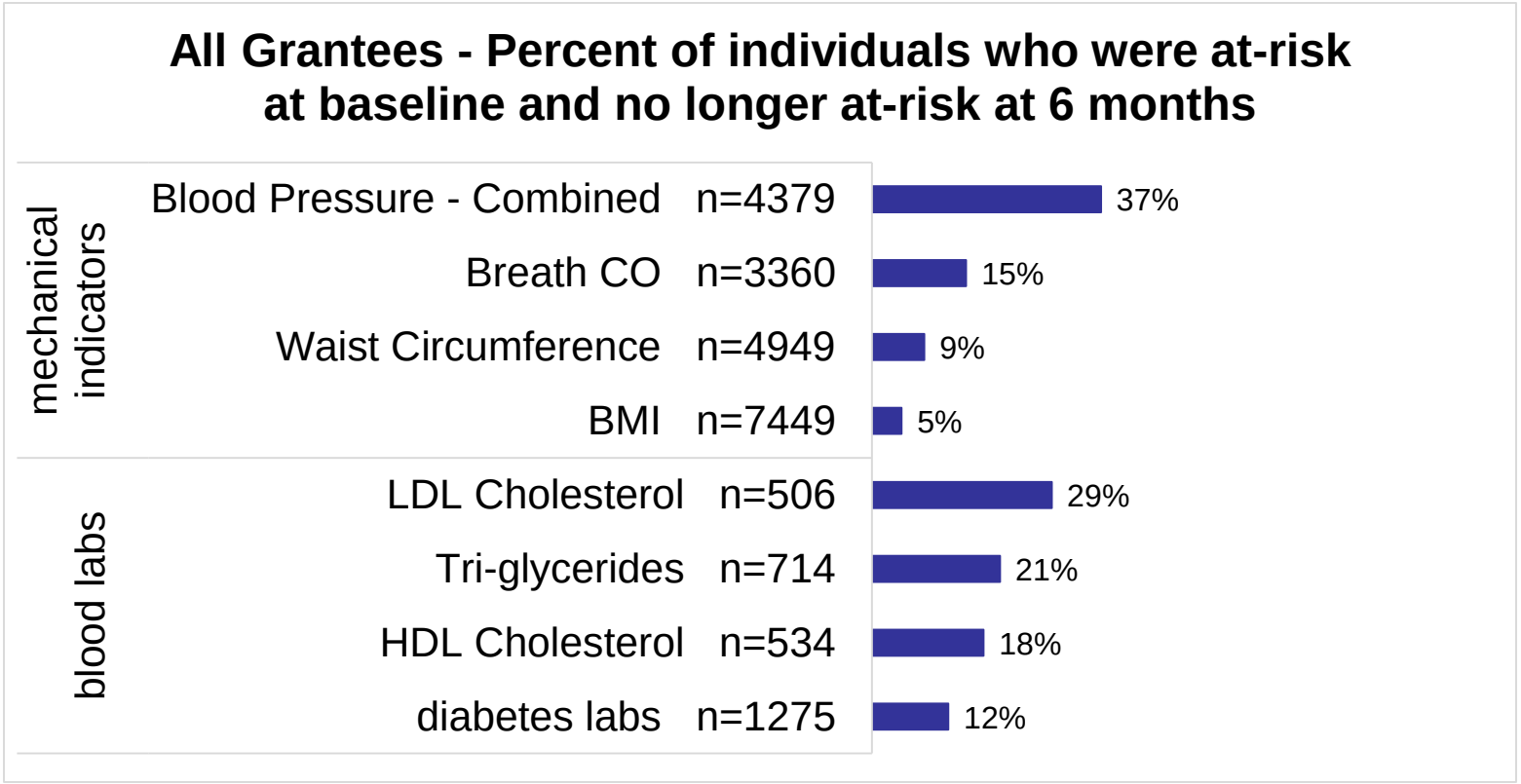
- Using mechanical health indicators and blood labs to measure baseline, improvements
- “Target-to-treat” approach





Effects of Interventions to Reduce Risks Factors

Small changes have a Significant Impact



"In God we trust, all others bring data" **(maybe W. Edwards Deming)**

Engagement & Treatment Adherence

- Keep It Simple [&] Stupid (KISS)
- Daily, weekly, monthly check-ins
- Mobile Meds / Pillboxes / Bubble packs
- 5 A's of Access to health care
  - affordability, availability, accessibility, accommodation, acceptability
- Flywheel Principle, i.e., building momentum for change
  - Engaging them with the "right" team member
- Behavior change / organizational change principles
- Hope
- Other?

"Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try."

- Atul Gawande, *Better: A Surgeon's Notes on Performance*

Sharing Experiences